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Barriers and Facilitators to Prenatal Care for Pregnant Latina Women in Cobb County, Georgia

Carol Holtz
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Abstract

This research study seeks to identify factors that serve as barriers and/or facilitators to prenatal care for Latina women and to provide data to assist health care providers, health care agencies, and policy makers in developing programs that maximize access to prenatal care for Latina women. In addition, other groups may also find this data useful, such as scholars in Latin American studies, immigration, cultural diversity, minority health care, and health care in general. The research questions consist of the following: (1) What do indigent pregnant (or recently delivered) Latina women believe about prenatal care? (2) What are the barriers to accessing prenatal care for these indigent pregnant Latina women? (3) What are the facilitators to accessing prenatal care for these indigent pregnant Latina women?

Review of the Literature

Need for Prenatal Care

Prenatal care is crucial to the health of mother and baby and has been recognized as the cornerstone of this country's health care system for pregnant women since the beginning of the 20th century. A growing body of research has demonstrated

a relationship between the use of prenatal care services and improved maternal and infant care. Factors that may be related to low birth weight babies include race, insurance status, and use of prenatal care. Prenatal care includes regular visits to a physician's office, clinic, or other health care facilities to monitor the health of mother and fetus. The suboptimal use of prenatal care has contributed to an increase in rates of low birth weight babies, premature births, maternal mortality, and neonatal mortality. Although adequate prenatal care is known to reduce the risks of low birth weight babies, nearly one quarter of all women giving birth in the United States receive delayed, inadequate, or no prenatal care and are at risk for having undetected complications of pregnancy. Early comprehensive prenatal care promotes healthier pregnancies by detecting and managing preexisting medical conditions, providing health behavior advice, and assessing the risk of complications such as low birth weight and preterm birth. Prenatal care serves as a gateway to the health care system, especially for low-income minority women (CDC. entry into prenatal care, 2000; CDC Reproductive Health Information Source Fact Sheet, 2000; March of Dimes, 1993; Monjaraz, 2001). Although one cannot truly put a price on the value of a healthy birth, real costs incurred from medical complications in newborns plague health care organizations. At least 25% of the complications resulting in infant deaths could be prevented if women received prenatal care. Spending \$1.00 on prenatal care is estimated to save \$3.00 in health care costs after the baby is born (CDC Reproductive Health Information Source Fact Sheet, 2000; Monjaraz, 2001).

A range of factors place pregnant women at risk of adverse birth outcomes: low educational attainment; poverty; illicit drug, alcohol, and tobacco use during pregnancy; and lack of social support. The highest risks encountered are multiple medical and social problems. While the organization and structure of regionalized perinatal care cannot change social conditions, it can work to assist and empower women by improving the interpersonal aspects of the system of care. The challenge is to develop new strategies, combining medical and social services into a coherent system that is family-centered and community-based. Pregnancy deaths occur more frequently in Latina women than in non-Latina European American women (CDC Surveillance and Research, 2004). Among U.S.-born Latina women, pregnancy related mortality ratios indicate that there are 8.1 deaths per 100,000 live births, and there is an even higher rate for foreign-born Latina women with 9.9 deaths per 100,000 as compared to European American women. Latina women with no prenatal care are at higher risk for mortality than those receiving some prenatal care (CDC Surveillance and Research, 2004).

Barriers to Accessing Prenatal Care

The effectiveness of prenatal care depends upon timely access and appropriate program content. Many of the same factors that are barriers to access and utilization of health care are contributors to poor health. Multiple barriers to prenatal services include (a) inadequate transportation, (b) lack of health insurance, (c) lack of belief in the effectiveness of prenatal care, (d) language barriers, (e) lack of childcare, (f) fear of the unknown, (g) chronic poor health status, (h) lack of social support, (i) very young maternal age, (j) concern about legal status in the country, (k) concern about detection of illegal activities, such as drug use, (l) family violence, (m) use of "home" remedies in place of prenatal care, (n) maldistribution of prenatal health care providers, and (o) history of perceived discriminatory experiences. There are definitive relationships among race/ethnicity, residence, maternal sociodemographic and medical risk characteristics, and use of prenatal care in the United States (Miller, Clarke, Albrecht, & Farmer, 1996; National Latina Institute for Reproductive Health, 2002; U. S. Office of Minority Health and Primary Healthcare, 2003).

Based on data from the National Maternal and Infant Health Survey, a recent study found important differences in prenatal care use by race/ethnicity and residence, as well as interactive effects of these variables. Single marital status, nonmetropolitan residence, poverty, low level of education, and no insurance were more strongly associated with inadequate prenatal care for European Americans and Latinas than for African Americans. Nonmetropolitan residents were more likely to receive inadequate care, regardless of race/ethnicity or sociodemographic characteristics. Predicted probabilities of prenatal care use by race/ethnicity and residence showed that, regardless of risk, nonmetropolitan Latina women had the highest probability of obtaining inadequate prenatal care. Results highlight the continued importance of race/ethnicity and rural residence in determining prenatal care use and the need to design interventions targeted to these populations (Miller et al., 1996).

Mexican Americans are the largest Latino subgroup in the United States, and 85% are U.S. citizens or legal residents. Of all ethnic groups, Latino Americans are the most likely to lack health insurance. Only 43% of this population has employment-based health insurance compared to 73% of European Americans. Nearly 4 in 10 Latinos are uninsured, the highest uninsured rate among all racial or ethnic groups. More often than any other group, Latino Americans have no regular source of health care. In addition, the low incomes of many Latino people make it difficult to obtain individual health insurance outside of employer or government sponsored plans (Health Care for Minority Women, 2000). Despite Latino men's having a higher rate of participation in the United States workforce

than other cultural groups, Latino families have the highest rate of poverty among all cultural groups. First generation Mexican Americans are primarily employed in construction, manufacturing, and the service areas, which do not always provide adequate health care benefits. Undocumented workers fare even worse, having low pay and few benefits, as job opportunities are limited (Stasiak, 2001). Experience in obtaining health coverage demonstrates the holes in the U.S. health insurance system. Lack of comprehensive health insurance limits Latina American women's access to regular health services for prenatal care, disease prevention, screening, diagnosis, treatment, and management of chronic and acute conditions (Health Care Access and Latina Women, 2001). Although research indicates that more women have been utilizing early prenatal care since the early 1990s, racial and ethnic disparities still exist, which indicate that lack of funds or health insurance may not be the only barriers to prenatal care. Non-Latino African American women, Latina women under 20 years, and women having less than a high school education are most likely to receive late or no prenatal care. Many of the immigrants come to the United States with limited elementary school education, which is reflective of the normative education level in Mexico, not a lack of interest in education (Stasiak, 2001).

Some Latina women who recently migrated from areas under conflict may have significant distrust of authoritative and paternalistic systems, including the U. S. health care system as they perceive it. One of the greatest reasons that Latina women often do not seek prenatal care is the fear that something bad will be discovered. As a result they may only seek care when they suspect something is wrong. Although many recently immigrated pregnant Latina women have good birth outcomes in spite of low prenatal care records, some of the second and third generation Latina origin women, especially the young and unmarried women, tend to have adopted lifestyles of smoking and drug use, which cause them to avoid prenatal care and have larger numbers of low birth weight babies and other poor birth outcomes (Schlosberg, 1998). System issues that cause barriers to prenatal care for Latina women include long waiting times in clinics and not enough space for families. Often women must bring other children with them to an appointment, and lack of childcare makes it difficult for them to stay for extensive periods of time (Miller et al., 1996).

Medicaid is a critical source of health coverage for Latino people, helping over 4 in 10 poor Latino individuals. Legal residents entering the United States after 1996 are not generally eligible for Medicaid, and those who are eligible may be reluctant to apply for Medicaid because they incorrectly fear it will jeopardize future citizenship or that they will be forced to repay Medicaid cost (CDC, 2001). Undocumented residents do not qualify for Medicaid, except for emergency care. The "Right From the Start" Medicaid program pays for the medical care required

by pregnant women up to 60 days after they give birth, for delivery, and for the medical care required by their children. Services covered include perinatal case management, postpartum home visits, and substance abuse day treatment for pregnant women. The program uses 235% of the federal poverty level as the ceiling for eligibility for pregnant women. Infants up to 1 year are covered at 185%. This makes Georgia's Medicaid benefits available to many pregnant women and children. Physician reimbursement for prenatal care and delivery has been increased from \$1,000 to \$1,205, and physicians are paid an extra \$100 if they begin prenatal care in the first trimester. Pregnant women may get coverage while waiting for their eligibility to be decided. Some hospitals, health departments, and community health centers will issue temporary Medicaid cards to eligible women when they apply. A pregnant woman qualifies if her monthly income does not exceed 235% of the federal poverty level. Examples include a family of two with monthly income of \$2,275, a family of three with monthly income of \$2,867, and a family of four with monthly income of \$3,457. A pregnant woman is counted as two people in calculation of family size. Her husband also counts, although husbands do not receive Medicaid coverage. In addition, a woman meeting the income standards can become eligible within 60 days after giving birth, even if she did not apply during pregnancy or delivery. Other barriers, including cultural and language differences, are significant factors that also reduce access to care. Latino people in the United States are the least likely among all ethnic groups to have usual provider access when they need care (Georgia Department of Human Resources, 2001; Health Care Access and Latina Women, 2001).

Because pregnancy among Latina Americans is viewed as a natural and desirable condition, many women do not seek prenatal evaluations. In addition, because prenatal care is not available to every woman in Mexico, some women do not know about the need for prenatal care. With the extended family network and the woman's role of maintaining the health status of family members, many pregnant women seek family advice before seeking medical care. Therefore "familism," a strong reliance on the family for advice and decision making, may deter and hinder early prenatal checkups. To encourage prenatal checkups, the health care provider can encourage female relatives and husbands to accompany the pregnant woman for health screening and incorporate advice from family members into health teaching preventive care services (Berry, 2002; Purnell & Paulanka, 1998, 2003; Stasiak, 2001).

Statistics of Latina Women in Georgia

The United States is currently experiencing the largest sustained immigration wave in its history with an estimated 1.2 million documented and undocumented

immigrants arriving each year, mostly from Latin America (Health Care Access and Latina Women, 2001). Latino people comprise approximately 15% of the U.S. population, and nearly one quarter of its uninsured people. Currently, the U.S. Census Bureau (2001) relates that Latinos have surpassed African Americans to become the majority of minority groups in the United States. It is estimated that by 2050 the number will increase to 97 million or 25% of the U.S. population. The U.S. Latino population includes Mexican Americans (which are the largest group), Puerto Rican Americans, Cuban Americans, Central and South Americans, and others (U.S. Census Bureau, 2001).

Georgia's "invisible population" of Latino people is now estimated to be close to 600,000 (U.S. Census Bureau, 2001). Approximately 46,800 Latinos live in Cobb County. The majority of immigrants to the state is from Mexico and has arrived in the past 5 to 10 years. This influx is the result of the economic crisis in Mexico and the expanding labor markets in the southeastern United States. The new population is changing the mosaic of urban and rural Georgia dramatically almost overnight. For example, from 1990 to 2000, Cobb County, Georgia, experienced a 400% growth increase in Latino population (Child Health USA, 2003). Included in this number is a significant percentage of the female population who are of childbearing age (Brown, 2000). In the southeastern United States, Miami has the largest population of Latinos followed by Tampa and then by Atlanta. Nationally, about 25% of the Latino population is Spanish-speaking only, and 25% of Latina immigrants over the age of 18 are illiterate. From 1990 to 1996 the Latino population in the Southeast increased 21.7% overall. The metropolitan Atlanta population increased 81%, and overall in Georgia, this population increased 72% (U.S. Census Bureau, 2001).

Health Risks for Pregnant Latina Women

Many of the Latina immigrants have a much higher rate of pregnancy complications due to a variety of causes than European American women. Pregnancy complications are the sixth leading cause of death in Latina females of childbearing age, and perinatal complications are the fourth leading cause of death in Latino children in the United States. Currently more Latina women die because of the lack of prenatal care than any other minority women's group. Latina women are bearing children at higher rates than any other group of childbearing women in the United States. American teenagers of Latina origin give birth at twice the rate of the national average and three times the rate of European American teens. Latinos born in the United States are more likely to have babies outside marriage and to have low birth rate babies than recent Latino immigrants (Garrett, Treichel, & Ohmans, 1998).

The first national study of pregnancy-related deaths of Latina women in the United States by the Centers for Disease Control and Prevention (CDC) revealed that pregnancy-related deaths occur more frequently in Latina women than in non-Latina women. Within the Latina female population, there are 10.3 deaths per 100,000 live births compared to a rate of 7.3 for non-Latina women. Because Latina women have a higher risk of death associated with pregnancy than non-Latina women, more research and surveillance are needed to determine the medical and nonmedical factors that contribute to the problem (Garrett et al., 1998).

From 1979 to 1992, a study of pregnancy-related mortality rates of Latina women in the United States reported that 623 of the 3,777 pregnancy-related deaths in the United States were of Latina origin. The pregnancy-related mortality ratio was 10.3 deaths per 100,000 live births among Latina women during this 14-year period, compared with 6.0 deaths among non-Latina European American women, and 25.1 deaths among non-Latina African American women. The risk of pregnancy-related deaths increased as Latina women grew older, as it did for non-Latina European American women and non-Latina African American women. For those Latina women with three or more live births, the risk of pregnancy-related deaths also increased (Garrett et al., 1998).

Latina women in this study who received no prenatal care had a higher risk of pregnancy-related deaths than those receiving some prenatal care (U. S. Office of Women's Health, 1998). This study further revealed that following a live birth or stillbirth, the leading cause of pregnancy-related deaths among Latina women was pregnancy-induced hypertension. Pregnancy-induced hypertension is responsible for about one-third of pregnancy-related deaths following a live birth or stillbirth among Latina women. Because pregnancy-related deaths from pregnancy-induced hypertension are preventable, experts recommend early prenatal care, subsequent detection of pregnancy-induced hypertension, and careful monitoring and treatment during and following pregnancy to prevent serious complications. Other leading causes of death for Latina women after a live birth or stillbirth are hemorrhage, embolism, and infection (American Public Health Association, 2000).

The Latina teen pregnancy rate dropped 4.8% between 1995 and 1996 but continues to be the highest in the nation. Many factors such as low income level, religious beliefs, and cultural traditions including the concept of machismo (the man having total decision-making power) may contribute to the high Latina teen birth rate. There are lower rates of elective abortions and lower contraceptive use rates than found among African American or non-Latino European American communities. High school graduation rates among Latina teenage mothers are very low as compared to other U.S.

population groups. Approximately 27% of Latina teen mothers complete high school by their mid-20s, compared with 67% of African Americans and 55% of European American teen mothers (Ness et al., 1999). Higher rates of vaginal infections in Latina women than in Asian or European American women may contribute to their increased risk for preterm birth (Health Care for Minority Women, 2000).

There is an increased risk of HIV exposure among heterosexual Latina women. When pregnant, these women are at high risk for transferring the HIV virus to the fetus. AIDS statistics reveal a very serious problem among Latina women. With less than 12% of the total U.S. population, Latina women represent 21% of new AIDS cases. The AIDS rate for this group of women is almost 4 times that of non-Latina women. In addition, Latina women often learn that they have the disease later than non-Latina women, and Latina women are more likely to have symptoms when they begin treatment for the illness (Health Care for Minority Women, 2000).

Latina mothers suffer increased risk of health conditions, which may adversely affect their current health and/or a current or future pregnancy. On the average Latina women have some of the highest fertility and birth rates, which puts them at higher risk for maternal morbidity and mortality, also endangering the health of the fetus/infant. Many Latina women suffer from low levels of folate, iron, vitamin A, and iodine, which are needed for proper fetal development. Severe iron deficiency anemia can cause cardiac failure in women and low birth weights, hypoxemic (low oxygen) level of the fetus, or stillborn deliveries (Health Care for Minority Women, 2000).

Latina women are at higher risk for developing diabetes Type II, which can increase the risk of a pregnancy (3 times greater risk than European American women). Fetal and neonatal deaths due to diabetes and pregnancy are 3 to 8 times more prevalent in pregnancies of diabetic mothers, and there is a greater risk for congenital malformations in children. Gestational diabetes in Latina women is 2 to 3 times more prevalent than in non-Latinas (Health Care for Minority Women, 2000).

Inconsistent and infrequent gynecological visits are another risk to childbearing Latina women. They are less likely to receive yearly PAP smears and less likely to be treated for sexually transmitted diseases, if they have them. Cervical cancer rates (2 to 3 times higher for European American women) and undiagnosed and untreated STDs are higher than for Latina women than European American women. Untreated cervical cancer or untreated STDs also place them at higher risk for pregnancy complications (Health Care for Minority Women, 2000).

Methodology

Design

The design of this study was a descriptive, cross-sectional, multimethod triangulated component design. In this type design, qualitative and quantitative components focus on the same phenomenon but are separate and discrete during data collection and analysis, than combined in the interpretation of the study. This allows for convergence of the phenomenon and increased validity (Polit & Beck, 2004). Specifically, the qualitative component consisted of two focus groups, from which data were collected for the development and validation of the questionnaire, which was the quantitative component.

Samples and Settings

The two samples were selected by means of convenience. The criteria for inclusion of participants were the same for both the focus groups and the questionnaire and represent the target population. They were Latina women, age 18 to 45, currently residing within the county where the research was conducted, indigent by Federal poverty standards, pregnant or having delivered within the last 12 weeks, speaking Spanish or English, and reading or writing in one or both of the languages. The settings for data collection were different. The participants of the focus groups were attending prenatal preparation classes at a local pregnancy services organization, whereas the questionnaire respondents were attending a Women, Infants, and Children (WIC) Clinic in the local health department.

Data Collection Instruments

A researcher-developed semistructured interview guide was developed and used for the focus groups, asking open-ended questions about their beliefs about prenatal care, in terms of barriers and facilitators. Based on the data from the focus groups and from the literature, a 33-item Likert scale prenatal questionnaire was developed. The ideas for the prenatal questionnaire came from the Pregnancy Risk Assessment Monitoring System (PRAMS) (Oregon Dept. of Human Services, 2005.) Three content experts judged the prenatal questionnaire to be relevant and appropriate to the topics being measured. The questionnaire was then piloted (pretested) on 10 Mexican women for readability and comprehension of the content and for accuracy of the Spanish language. The questionnaire was subsequently modified based on their input. This modification included changing the five-point Likert scale to a three-point scale, because the

women said that the five choices were too difficult, culturally, to answer. It was noted that in the Latino culture, there are not clear language translations for all the ranges, and it is culturally difficult to differentiate across a five-point scale. (The categories of Strongly agree, Agree, Neutral, Disagree, Strongly disagree, and Not applicable were changed to Agree, Neutral, Disagree, and Not applicable.)

Qualitative Design Procedure and Analysis

The first phase of this study was the qualitative design utilizing two focus groups conducted with open-ended questions concerning prenatal barriers and facilitators. The researchers obtained the convenience sample from pregnant women attending Spanish prenatal preparation classes on Thursday evenings at a privately funded county pregnancy services agency. Four women agreed to participate in the study, two in each of the two focus groups. The women who agreed to participate signed the Kennesaw State University Institutional Review Board (IRB) consent forms after a full explanation of the research and clarification of any questions. All IRB protections were complied with, such as informing the participants that they could change their minds and leave the study at any time with no penalties or repercussions. They were informed that their names would not be attached to any of the data, and they would receive \$10 for their time and energy. All the women spoke only Spanish. Dr. Holtz, who is fluent in Spanish and very experienced with the Mexican culture, conducted the focus groups. The sessions were tape recorded and lasted approximately 40 minutes. The data were analyzed by content analysis of the themes.

Quantitative Design Procedure and Analysis

The second phase of this study was a quantitative design utilizing a 33-item multiple-choice questionnaire in Spanish and in English along with sociodemographic questions. The questions were based on the data elicited from the qualitative study and a review of the relevant literature. The staff nurses at the WIC Clinic at the Cobb County Health Department assisted in recruitment of participants. After the researcher explained the purpose of the study to the women in the WIC Clinic, a total of 103 women volunteered to participate in the survey and signed the IRB consent forms. They were informed that they could change their minds and leave the study at any time and they would have no penalties. They were also told that their names would not be attached to any data, and they would receive \$10 for their time and energy.

The majority of women spoke only Spanish, and all requested a Spanish version of the questionnaire. The participants were attending the WIC clinic and were present

in a waiting room either to register for vouchers for food and formula or to attend nutrition classes. A special children's playroom was adjacent to the waiting room, and several of the women were with their children in this room. The researcher assisted them in filling out the sociodemographic section of the questionnaire. Many did not fill out this part of the questionnaire completely or left it blank but continued with the second part by filling out the responses to the multiple-choice questions. The process of answering the survey took participants about 45 to 60 minutes. Data were later analyzed using Statistical Package for the Social Sciences (SPSS).

Results

Qualitative Results

Four Mexican women participated in the focus groups, two in one group and two in the other group. (Refer to Table 1.) They were young, indigent, pregnant women with little education who spoke only Spanish. They were married or single, and had zero to four living children, but no children were living with them. They did not have health insurance, and they used taxis for transportation.

Table 1. Sociodemographics and Characteristics of Focus Group Participants (N=4)

Characteristics	Range	Frequency
Age	23–25 years old	
Education	3–6 years	
Occupation, housewife		4
Income, household	\$1,000–\$1,400/month	
Birthplace, Mexico		4
Years in USA	2–4	
Language, Spanish		4
Prenatal care		4
Prenatal visits	2–6	
Pregnant, currently		2
Delivered, past 3 mos.		2
Pregnancies	1–4	

Table 1 (continued).

Characteristics	Range	Frequency
Premature babies		1
Living children	0–4	
Children living w/ them		0
Started prenatal care at:	3–4 months pregnant	
Substance abusers		0
Health insurance		0
Transportation (taxi)		4

The researchers did not ask the women about their immigration status because the topic is a very sensitive subject, and it might have frightened them away from participating in the group. Even so, the women appeared to be somewhat shy and possibly intimidated when talking to the researchers. One woman put a paper in front of her face initially when speaking and later put the paper down. They spoke in very soft voices. The women knew that their discussion was to be taped, yet the researchers believed that the tape recorder would add to their discomfort, so they put the tape recorder on a chair in the corner of the room, rather than next to the participants. Based on the analysis of the data, the following themes were extracted.

Theme 1: Prenatal care is better here than previous experiences in Mexico. (Better prenatal care.)

- “When I had my prenatal care and then my baby in Mexico, my private parts [genitalia] have never been the same! I don’t know what they did to me!”
- “Sometimes I went for prenatal care in Mexico and there was no money to pay. My husband was unemployed and we couldn’t afford it.”
- “Treatment is better here. I went to a private hospital in Mexico and it was not very clean.”
- “In Mexico they left you alone. Some women had their babies alone with no one with them. It’s not like that here. They check on you often.”
- “The care for your nutrition is better here. They tell you here to drink more juice and milk.”

Theme 2: More alone, having less family here. (Social isolation.)

- "Here I only have my husband. The rest of my family is in Mexico."
- "My husband works all the time. I can't get a job because I can't speak English. You need English here to work."

Theme 3: Language barriers/negative attitudes of care providers. (Negative experiences.)

- "There are those who know English and Spanish in the clinics, but do not want to help a person."
- "I need more information and better explanations."
- "More than anything else, I need a Spanish speaker in order to understand a bit more of what is said. Having an explanation when pregnant is important. Sometimes the translations are not accurate or properly done."
- "Sometimes they help, but with a bad attitude.... they get mad!"
- "There was no one there to explain in Spanish what is happening to my baby."

Theme 4: Payment issues. (Lack of money.)

- "When one is pregnant, if one has no money, one should be able to get help the day of the appointment and pay a little afterwards."
- "If one has no money they should make us pay half and the other half later because one's husband sometimes does not make enough money to pay \$150 or \$200."
- "I pay for a taxi to get to the clinic because there is no other way to get there."

Theme 5: Helpful things learned in the prenatal clinic. (Health education.)

- "It's important to learn about the changes necessary for diet, about the baby, and everything else."
- "I learned about prescriptions, vaccinations, care..."
- "I'd like to learn more because I don't know very much."
- "Prenatal care is important for the baby to be born better. I don't know of the consequences if they are born with problems."

The participants in the focus groups revealed their main prenatal concerns. One concern was the language barrier and attitudes of the staff. They stated that not knowing English was a big problem for the participants. Sometimes

they would find staff who spoke Spanish, and other times they would not. They also stated that even those who spoke Spanish did not always treat them with respect or have a good attitude toward helping them by adequately answering their questions. They also were concerned about costs in the health department clinics, stating that they could not always pay the sliding scale fees, because their husbands were sometimes unemployed, and they themselves could not work to help out, because they spoke no English. They stated that it was necessary to speak English to get a job.

When comparing the care in Cobb County, Georgia, with previous care in Mexico, they stated that in Cobb County the facilities are much cleaner. And when a woman is in labor, there is always someone to check on her, and she is never alone when she delivers. They also stated that the clinics do provide much needed information about nutrition and lifestyle changes that are needed, and that they give information about body changes during pregnancy and childcare. Because the participants have less family around for social support, they perhaps feel more alone, do not get advice from family members as in Mexico, and do believe that prenatal care is very important for their babies' health.

Quantitative Results

Although there was a total of 103 participants, only 62 answered the sociodemographics questions. (See Table 2.) Fifty-eight (96%) of these 62 women were young Mexican women, and all 62 were Spanish speaking. They were young, indigent, with little education, were mainly living with the father of the child or married, had no health insurance or were on Medicaid, and most used a taxi for transportation.

The remaining 41 women of the 103 sample were a mixture of Latinas, African Americans, recent African immigrants, and European Americans. Several spoke English, and several spoke Portuguese. All 103 were indigent women with either Medicaid benefits or no health insurance, and all were either pregnant or had delivered within the last few weeks.

The findings from the questionnaire data revealed some common responses. The most frequently reported barrier to prenatal care was the cost. (See Table 3.) The participants felt that prenatal care costs too much, and they cannot afford it. The second barrier most frequently reported was language. Most participants spoke only Spanish and were unable to communicate with health care providers who spoke only English or limited Spanish. Unexpectedly, the third most frequent barrier reported was worry; they worried about their safety when they left home. Other common barriers to prenatal care that were expected included being concerned about legal status, needing child care when attending clinics,

needing transportation to go to clinics, believing that prenatal care was not worth the effort, disliking waiting times in the clinics, not being able to take off from work, not knowing how to find prenatal services, and believing that prenatal care was not necessary (since they had not had it with previous pregnancies and they had no problems). Although few in number, there were reports of not wanting the baby (11), having a frightening home life (9), and engaging in activities that could harm the baby (7).

As for the prenatal facilitators and beliefs of the participants, 101 (out of 103) participants reported that prenatal care was useful in detecting pregnancy problems. (See Table 4.) The other most frequently reported facilitators of prenatal care reflected positively on health care providers. The participants reported that talking to health care providers about their problems was useful. Health care providers also answered their questions, taught them well, treated them with respect, and communicated well with them. The majority of respondents also valued prenatal care, believing they could increase their chances of having a healthy baby by using prenatal care.

Table 2. Sociodemographics and Characteristics of Participants in Prenatal Questionnaire

Characteristics	Percent/#	Mean	Median	SD	Range
Age		26	26	5.4	18–38
Education (years)		8	6	3.5	0–13
Income, household (wk)		\$330.00	\$300.00	\$237.00	\$0–1,700
Martial status					
<i>Single</i>	20% (12)				
<i>Married</i>	34% (21)				
<i>Living with father of child</i>	46% (29)				
Birthplace, Mexico	94% (58)				
Years in USA		6	4	5.3	0–20
Language, Spanish	100% (62)				
Prenatal care (PC)	100% (62)				
Pregnancies		2.4	2	1.4	1–6
Premature babies		0.2	0	0.7	0–5
Started PC (mos. pregnant)		2.8	2	1.9	0–7

Table 2 (continued).

Characteristics	Percent/#	Mean	Median	SD	Range
Substance abusers	0% (0)				
Health insurance					
<i>Medicaid</i>	39% (24)				
<i>None</i>	40% (25)				
Transportation					
<i>Taxi</i>	50% (31)				
<i>Car</i>	32% (20)				
<i>Bus</i>	3% (2)				

Table 3. Prenatal Barriers and Beliefs

Felt that prenatal care costs too much and they could not afford it.	39% (40)
Spoke only Spanish and were unable to communicate well with the staff.	35% (36)
Preferred not to leave home (worried about safety).	34% (35)
Worried about their legal status when using prenatal care.	24% (25)
Needed child care while attending prenatal care.	27% (28)
Did not have transportation.	26% (27)
Believed that prenatal care was not worth the bother.	20% (21)
Had to wait too long to get services when they had an appointment.	19% (20)
Could not afford to take off from work to go for prenatal care.	18% (19)
Did not know how to find prenatal services.	18% (19)

Table 3 (continued).

Believed that prenatal care was not necessary because they did not have it with previous pregnancies and everything went fine.	17% (18)
Did not have the energy to go to prenatal care.	15% (15)
Did not get prenatal care because they did not know they were pregnant.	14% (14)
Had husband, partner, or other family members who did not want them to go for prenatal care.	14% (14)
Had mother, sister, aunt, or girlfriends who did not receive prenatal care and had healthy babies, so they did not think it is necessary for them.	13% (13)
Used people in their family to help them with their pregnancy and did not need to go to prenatal care.	12% (12)
Did not feel well enough to go to prenatal care.	12% (12)
Were worried about their pregnancy, afraid to find out any problems.	11% (11)
Did not want the baby—so no need for prenatal care.	11% (11)
Had frightening home life, and had no time to worry about prenatal care.	9% (9)
Involved in activities that could harm their baby, and they were afraid others would find out and get them in trouble.	7% (7)

Table 4. Prenatal Facilitators and Beliefs

Reported believing that prenatal care was useful in detecting pregnancy problems.	98% (101)
Said prenatal care was useful in talking to nurses and doctors about these problems (pregnancy, financial, & social ones).	92% (95)
Reported that their questions were always answered in the prenatal clinic.	83% (85)
Said they received good teaching in the clinic about caring for themselves and the baby.	83% (85)
Said they were treated with respect in the clinic.	82% (84)

Table 4 (continued).

Valued prenatal care and believed that they could have a healthy baby with prenatal care.	80% (82)
Had received prenatal care before, were satisfied with it, and planned to use it again.	79% (81)
Said they were able to communicate well with the staff.	45% (46)

Discussion

The common themes expressed by the focus groups and questionnaire participants were the barriers of cost of prenatal care and language of health care providers, although the focus group participants reported that prenatal care was better here in the United States than in Mexico, and they gained health knowledge from prenatal care here. The barrier of cost of prenatal care confirms previous findings (CDC. Entry into Prenatal Care, 2000), as does the need for health care providers who speak Spanish (Schaffer, 2002). Although social isolation was reported by the focus group participants, it was not reported by the questionnaire participants. But what the questionnaire participants did report was that they preferred not to leave their home because they worried about their safety. This preference may be a factor in the social isolation that was expressed by the participants in the focus groups. In other words, if one tends to stay at home a lot, one may feel a degree of social isolation from the community at large. Being worried about their safety outside their home may be related to the possibility of their living in high crime areas due to their lack of financial resources.

Overall, the questionnaire participants seem to have reported lower percentages of barriers and higher percentages of facilitators than the authors anticipated. This may be explained by a social desirability response set in which participants tended to answer how they thought they should answer the questions, rather than answering them truthfully (Polit & Beck, 2004). It could also pertain to the Hawthorne effect in which knowledge of being included in a study changes behavior or even the acquiescence response set in which one agrees with the items regardless of the content. But an argument against the acquiescence response set is the fact that the questions were worded in both positive and negative directions in order to avoid such bias.

The lack of transportation, lack of child care, inability to leave work, inability to find services, wait time in clinics, and concerns over legal status were expected barriers. But what was unexpected were 34% of the women were worried about their safety outside their home, 9% stated their home life was very frightening

(domestic violence), and 11% said they did not want the baby. If the social desirability response set was working in these cases, these percentages could possibly be higher than reported. That is, the participants may be under-reporting about their home life being frightening and not wanting their baby, since these may be shameful and stigmatizing conditions. As for facilitating factors to prenatal care, almost all of the respondents reported prenatal care to be useful in detecting problems; they valued prenatal care and believed that they could have a healthy baby with prenatal care; and they said that staff answered their questions and taught and respected them.

One major limitation of this study is convenience sampling, which threatens external validity and tends to decrease the ability to generalize the findings from the sample to the target population of Latina women in the United States. Also, the questionnaire needs to be further validated, and reliability needs to be established with other samples of Latina women. Thought should be given to overcoming the problem of not being able to use a five-point Likert scale in data collection, which the pretest showed to be too culturally difficult to answer. Are there other methods of conducting quantitative studies with similar Latina women that would achieve a spread of responses like the five-point Likert scale?

Another research issue is the reluctance of the Latina women to give demographic data, and if they did, to allow it to be linked to the responses from the questionnaire. Although they may be worried about the loss of confidentiality regarding the data (especially as it relates to legal status), this situation limits the analyses, interpretation, and conclusions. Significant correlations between sample characteristics and prenatal care barriers and facilitators might have been uncovered if demographic data were given and could be linked to the questionnaire data.

Conclusion

Based on the reported barriers to prenatal care, health care providers, health care agencies, social and mental health workers, and policy makers need to be political, social, cultural, and health advocates for indigent pregnant Latina women in the United States to assist in removing the barriers to prenatal care for them. Public health providers and agencies can begin with seeking more funding for prenatal care, transportation, childcare, Spanish interpreters, social and mental health services for domestic violence and drug use, and garnering police protection in the areas where the women reside. Strategies to assist in removing financial barriers for pregnant Latina women include educating Latina women and the community about the need for financial assistance for prenatal care, the need for Spanish translators in prenatal care, and the need for public

safety in Latino neighborhoods. (See Table 5.) These are the major concerns of the study participants, with other concerns being childcare, transportation, and knowledge about services. Culturally congruent mental health services should help to address the issues of social isolation, frightening home life (domestic violence), and activities that could harm the babies.

The researchers recommend that this study be replicated, using a probability sample of Latina women from other parts of the United States and with other Latinas besides Mexican. It would also be helpful to have the sample representative of various socioeconomic groups other than indigent Latina women. Prenatal care can improve maternal and infant health, a valuable resource for our country and its people. And the more knowledgeable health care providers, health care agencies, and policy makers are about Latino cultures, the more likely they can translate their knowledge into improved health care for the Latina mothers and babies, which in turn, improves the health of the total community.

Table 5. Strategies to Assist in Removing Financial Barriers for Pregnant Hispanic Women

1. Educating Hispanic women about private insurance, Medicaid, and any type of self-pay programs.
2. Educating the local community about the need for prenatal care for Hispanic women who are not eligible for Medicaid and cannot afford private pay insurance—and seeking its support in funding.
3. Educating Hispanic women about other supporting services such as Women, Infants, and Children (WIC), family planning, and women's health services.
4. Participating with the local community to establish community-based Medicaid Presumptive Eligibility sites (Williams et al., 2003).
5. Determining the feasibility of having outreach staff who are linguistically and culturally congruent with the Hispanic women.
6. Advocating for improved access to prenatal services for providing transportation and childcare for Hispanic women.
7. Providing access to mental health services for Hispanic women, especially for domestic violence and drug abuse issues.
8. Collaborating with public health and community officials in obtaining funding for increasing the number of bilingual public health nurses and other staff.
9. Expanding culturally competent prenatal care through liaisons between local services agencies and nursing and medical schools.

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